

**Department of Health Care Services  
Proposed Trailer Bill Language**

Coordinated Care Initiative  
**Long-Term Services and Supports Integration**

**FACT SHEET**

The FY 2012-13 Governor's Budget proposes the Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for Medi-Cal beneficiaries, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. This document outlines the Long-Term Supports and Services (LTSS) integration component of the trailer bill language (TBL) that would implement the Coordinated Care Initiative.

**Intent of the Legislature**

This proposed TBL states the Legislature's intent that the state's most vulnerable populations have LTSS integrated into managed care plans to produce better health outcomes. In furtherance of this intent:

- Medi-Cal beneficiaries shall receive Medi-Cal and LTSS through coordinated health care systems offered by Medi-Cal managed care plans.
- Such coordinated systems shall promote beneficiary independence and use of home- and community-based services and reduce unnecessary use of emergency and hospital services.
- Managed care plans shall develop and expand their care management and coordination practices with counties, nursing facilities and other home- and community-based services.
- Medi-Cal managed care plans shall be expanded over a three-year period, starting January 1, 2013, to all counties.
- To the extent possible, for Medi-Cal beneficiaries enrolled in the federal Medicare program, the department shall work with the federal government to coordinate financing and incentives to allow managed care plans to deliver and coordinate the full scope of Medicare and Medi-Cal benefits, including long-term services and supports.
- The department, in a coordinated effort with the federal government, shall ensure continued strong beneficiary protections, choice of providers, and beneficiaries' ability to self-direct their care, as well as robust monitoring and oversight of managed care plans.
- The counties, which play significant roles in the provision of LTSS, will continue their role in assessing beneficiaries and authorizing hours in the In-Home Supportive Services (IHSS) program.

**LTSS Proposed to be Managed Care Plan Benefits**

In a phased-in manner described further below, the TBL proposes that the department would pay managed care health plans a capitated rate that includes all Medi-Cal benefits covered under the managed care health plan contract, including LTSS. In counties where the dual demonstration proposal is implemented, Medi-Cal beneficiaries would need to be enrolled in a Medi-Cal managed care plan in order to receive any

LTSS through the Medi-Cal program.

The TBL proposes specific LTSS to be included as benefits to be offered by Medi-Cal managed care plans, in addition to the Medi-Cal benefits that they already offer. The LTSS include:

- In Home Supportive Services (IHSS),
- Community-Based Adult Services (CBAS),
- Multi-purpose Senior Services Program (MSSP),
- Inpatient nursing facility and subacute care facility, and,
- LTSS provided under the current home and community based services 1915(c) waivers.

### **Populations Affected**

The LTSS integration into managed care would apply to most Medi-Cal beneficiaries, including individuals with Medicare and Medi-Cal coverage (“dual eligible beneficiaries”) and Medi-Cal only seniors and persons with disabilities (SPDs).

Beneficiaries who would continue to receive Medi-Cal services, including LTSS, on a fee-for-services basis include the following:

1. Individuals who have other health care coverage,
2. Children in the state’s Foster Care Program,
3. Enrollees of Program of All-inclusive Care for the Elderly (PACE),
4. Enrollees of the AIDS Healthcare Foundation, and
5. Other populations as determined by the Department of Health Care Services (DHCS).

### **Phase-in of LTSS Integration**

The TBL proposes phasing in LTSS integration over a three-year period.

- Beginning July 1, 2012, CBAS will be the first LTSS to be integrated. CBAS will be a Medi-Cal benefit covered under every managed care health plan contract and available only through managed care health plans, in Medi-Cal managed care counties.
- Beginning no sooner than January 1, 2013, with federal approval, the department will implement LTSS integration and the Duals Demonstration in up to ten counties that already have Medi-Cal managed care plans;
- Beginning no sooner than January 1, 2014, the department may expand provision of LTSS through managed care plans into all remaining counties that currently provide Medi-Cal through managed care.
- Beginning no sooner than January 1, 2015, the department will expand the provision of LTSS through managed care plans into all remaining counties, consistent with the proposal to expand managed care to current fee for service (FFS) counties in June 2013.

### **Beginning July 1, 2012:**

- CBAS will be the first LTSS to be integrated. CBAS will be a Medi-Cal benefit covered under every managed care health plan contract and available only through managed care health plans in Medi-Cal managed care counties. Medi-Cal beneficiaries who are eligible for CBAS will be required to enroll in a managed care health plan in order to receive this service. Managed care plans will be required to determine a plan member's medical need for CBAS and days of attendance using the assessment tool and eligibility criteria established per an approved federal waiver or amendments for these services.

### **Beginning January 1, 2013, in up to ten counties with Medi-Cal managed care plans where the dual demonstration project is implemented:**

- **MSSP** will be a Medi-Cal benefit available only through managed care health plans. In counties or geographic regions where MSSP exists, managed care health plans will contract with designated MSSP providers or integrate the MSSP care management personnel into the plans care management systems for provision of care coordination.
- **Nursing facility and subacute care services** will be available only through managed care health plans. Managed care plans will authorize utilization of nursing and subacute care facility services for plan members who have medical needs for these services.
- **Home and community-based waiver services** under Section 1915(c) shall be benefits available only through the managed care plans, to the extent approved by the federal government.
- **IHSS** will be available only through enrollment in a Medi-Cal managed care health plan. **Counties will continue to perform assessments and authorize hours, and consumers will continue to select and direct their provider.**

### **IHSS as a Managed Care Benefit**

IHSS services will be provided to plan members based on their needs, in accordance with existing IHSS statutory and regulatory requirements and guidelines. Additionally, health plans will:

1. Ensure access to, provision of, and payment for IHSS providers.
2. Continue to allow recipients, as employers, to select, engage, direct, supervise, schedule, and terminate IHSS providers.
3. Assume all financial liability for payments.
4. Create a care coordination team, as needed, for individual care plan development that may include county IHSS social workers, consumers and their representatives, managed care health plans, providers, and others as applicable.
5. Ensure compliance with Community First Choice Option requirements.
6. Adhere to quality assurance provisions, individual data, and other standards and requirements specified by the California Department of Social Services (CDSS), DHCS, and the federal government.

7. Enter into contracts with the county social service agencies to perform the following activities: assessments, enrollment of providers, IHSS provider background checks, quality assurance, and recovery of overpayments.
8. Enter into contracts with the county public authority to perform activities such as: collective bargaining of wages and benefits, maintaining a registry of IHSS providers, criminal background checks and training.
9. Enter into contracts with CDSS to perform the following activities: performing obligations of plan members as employer (payroll and various management of taxes and benefits), maintaining a data base of plan members/IHSS recipients' assessments, IHSS utilization, IHSS provider information, and conducting quality assurance.
10. Reimburse CDSS timely to meet payroll and other obligations.

### **IHSS Consumers' Rights in Managed Care Plans**

IHSS consumers receiving IHSS through managed care health plans would continue to have a right to:

- a. The ability to request a reassessment upon change of circumstances
- b. Hire, manage and fire providers of their choice
- c. Function as the employer and direct their service providers
- d. An appeals process

### **CDSS Role in Managed Care Plans**

CDSS shall retain all administrative functions for IHSS, in coordination with DHCS, including policy development, quality assurance, workers compensation, and program integrity.

### **County Maintenance of Effort in Sharing IHSS Cost in Managed Care Plans**

In counties where the dual demonstration is implemented and IHSS is a Medi-Cal managed care benefit, counties shall continue to participate in the non-federal share of IHSS costs through a newly-established County IHSS Maintenance of Effort (MOE). This MOE will be equal to the amount that would have been expended by the county in the absence of LTSS integration with managed care. The level of a county's MOE shall be determined by the Department of Finance in consultation with the California State Association of Counties. In addition, the MOE will be readjusted to include the county share of any increase in IHSS expenditures that is the result of factors other than an increase in caseload or authorized hours.

### **LTSS Universal Assessment Tool in 2015**

In conjunction with CDSS and California Department of Aging, DHCS will establish a stakeholder workgroup to design, develop, and test a Universal Assessment tool. The universal assessment process shall be used for all home and community-based services, including IHSS. It will build upon the IHSS Uniform Assessment process, Hourly Task Guidelines and other appropriate home and community based services assessment tools.

No later than June 1, 2013, the universal assessment stakeholder workgroup will convene. The stakeholder workgroup shall include, but not be limited to, Medi-Cal

beneficiaries and their representatives, managed care health plans, counties, providers, and legislative staff.

Beginning January 1, 2015, or upon completion of design, development, testing, and training of the universal assessment tool, managed care plans, counties, and home- and community-based service providers shall use the tool to determine home and community based service needs of their members. Counties will use this tool to continue performing the IHSS assessment and authorization processes, including final determinations of IHSS hours, on behalf of the Medi-Cal managed care health plans and in accordance with statutory provisions for IHSS eligibility.

This universal assessment process for home- and community-based services will be in addition to the assessment process used by managed care health plans when beneficiaries initially enroll in managed care.

### **Accountability to the Legislature**

Between January 2012 and December 31, 2014, the department shall provide the fiscal and policy committees of the Legislature with copies of reports submitted to the Center for Medicare and Medicaid Services (CMS) that are required under an approved federal waiver, waiver amendments or any state plan amendment for LTSS integration.

### **Termination of Specific Services or LTSS integration**

Annually on September 1, if the Department of Finance determines that the actions proposed in this TBL have caused utilization changes that result in higher state costs than would have occurred absent the proposal, after fully offsetting implementation and administrative costs, the Department of Finance shall notify the Legislature, DHCS, CDSS and Department of Aging, and those departments shall discontinue the provision of services in this TBL. Ninety days after certification by the Department of Finance, this TBL shall cease to be effective.

### **Summary of Arguments in Support:**

This TBL proposal is a continuation of California's effort to rebalance service delivery away from institutional care and toward home- and community-based care and to optimize the use of Medi-Cal resources. These combined efforts will help manage health care costs as California's population continues to age. National experience in states like Massachusetts, as well as California's own experience through PACE (Program of All-inclusive Care for the Elderly), have shown that integrating and coordinating medical care and LTSS will help Medi-Cal beneficiaries avoid unnecessary hospitalization and placement in nursing facilities.

This proposal addresses the current fragmentation of services, funding, and accountability for health outcomes by integrating all funding sources into capitated payments to managed care plans. The plans will be held accountable for ensuring their enrollees' health and well-being. Moving toward increased use of capitation also addresses the current incentives under the fee-for-service model that maximize provision of, rather than coordination of, services.

This proposal would achieve savings of approximately \$678.8 million General Fund in 2012-13 and \$950 million General Fund in 2013-14.

Additionally, this proposal would:

- Establish care management programs for Medi-Cal beneficiaries that coordinate services; better align benefits, delivery, financing, and administration; improve care continuity and coordination across medical, LTSS and behavioral health services.
- Create a coherent delivery system that is specific and responsive to beneficiaries' needs and eliminates fragmentation and inefficiencies created by current categorical funding, services structures, and regulatory requirements.
- Create much-needed savings for the State by lowering utilization of high-cost acute and long-term care services, shifting beneficiaries from institutional services to home- and community-based services, and establishing shared savings between Medicare and Medi-Cal.

### **Legislative History**

**AB 1040 (Bates, Chapter 875, Statutes of 1995)** required the Department of Health Services (DHS, now DHCS) to establish a pilot program (of up to 5 pilot projects) to integrate the delivery and funding of long-term care services and to evaluate the results. The bill also required setting a capitated rate for payment unless the department determined one or more integrated programs could not be capitated. The bill also repealed the establishment of a long-term care integration pilot program enacted in Chapter 305 of the Statutes of 1995.

**AB 2780 (Gallegos, Chapter 310, Statutes of 1998)** contained provisions to implement the 1998-99 Budget that directly affected the Department of Developmental Services, Department of Mental Health, Department of Alcohol and Drug Programs, Managed Risk Medical Insurance Board, and DHS (now DHCS). Among other provisions, the bill authorized DHS to contract with a non-profit entity to facilitate the development of community-based long-term care integration pilot projects.

**AB 3054 (Committee on Aging and Long-Term Care, Chapter 537, Statutes of 2002)** required DHS (now DHCS) to develop at least, but not limited to, one alternative model to the Long-Term Care Integration Pilot Program and allowed the department to consult with an established waiver technical advisory committee to assist in the development of the alternative model(s). The bill also required DHS to report the recommendation of the waiver technical advisory committee to the Legislature on or before December 1, 2003.

**SB 208 (Steinberg, Chapter 714, Statutes of 2010)** implemented several changes to the Medi-Cal Program as proposed in the state's application to renew the state's Section 1115 Medicaid Waiver. This legislation also gave DHCS the authority to establish the dual eligible beneficiary demonstration project to give those eligible for Medicare and Medi-Cal a continuum of services and maximize coordination of benefits.